Transition to ICD 10 CM/PCS – Preparing for October 1, 2015

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ICD-10-CM/PCS Trainer
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10 am - Noon

By attending this workshop, participants will

• Describe the structure and organization of ICD-10-CM
• Identify similarities and differences between ICD-9-CM and ICD-10-CM coding guidelines and coding conventions
• Apply general coding guidelines by completing exercises and case studies
Book for 2014 Sessions

- Basic 1CD-10-CM/PCS Coding
  - Schraffenberger, Lou Ann
  - AHIMA AC200512

- Chapter 1 Introduction to ICD-10-CM
- Chapter 3 Official ICD-10-CM Coding Guidelines, pp. 56-67
  http://www.cdc.gov/nchs/icd/icd10cm.htm

Settings requiring ICD-10-CM

- ALL healthcare settings, because ICD-10-CM required for ALL diagnosis coding
- Will affect every part of HCOs, not just coders
Why ICD-10-CM?

- ICD-9-CM
  - Outdated/obsolete due to HIPAA’s requirements for electronic transactions and code sets
  - Designed for indexing purposes; now, also being used for reimbursement

- ICD-10-CM
  - Will enhance efficiency of clinical data collection and quality of administrative data

Coded Data are used for

- Designing reimbursement systems, w/ emphasis on processing claims
- Measuring safety, quality, & efficacy of medical care
- Designing healthcare delivery systems
- Setting healthcare policy
- Monitoring resource utilization
- Improving financial, clinical, & administrative performance
Coded Data used for

• Providing healthcare consumers w/ data on cost and outcome(s) of treatment options
• IDing, tracking, & managing public health risks and disease processes
• Recognizing & IDing abusive or fraudulent reimbursement trends
• Conducting healthcare research & clinical trials
• Participating in epidemiological studies

ICD-10

• The World Health Organization (WHO)
  • owns and maintains the ICD system
  • released tenth revision of ICD system in 1992
ICD-10 Development

- ICD-10’s goals:
  - Expand content, purpose, and scope of system
  - Include ambulatory care services
  - Increase clinical skills
  - Capture risk factors in primary care
  - Identify emergent diseases
  - Group diagnoses for epidemiological purposes

- ICD-10’s purposes:
  - Promote international agreement & comparability in classification, collection, processing, & presentation of health data
  - Provide international diagnostic classification for epidemiological & healthcare purposes
  - Allow reporting of all mortality/morbidity data to the WHO

ICD-10-CM Development

- ICD-10-CM - 1st US version of ICD-10
  - ready for testing in 1997
  - 1997 to 2002 - NCHS tested several drafts
  - AHIMA tested a draft (released in June 2003)
  - Cooperating Parties
    - Advice & Assistance – AHA, AHIMA
    - Maintenance of Procedures – CMS
    - Maintenance of Diagnoses - NCHS
  - Implementation of ICD-10-CM now scheduled for October 2015
ICD-10-CM Benefits

- Provides greater specificity of clinical data and information relevant to ambulatory and managed care encounters
- Allows possibility of increased expansion of codes
- Includes risk factors in primary care, in addition to classification of diseases & injuries
- Includes recently identified diseases
- Updates general terminology and disease classification to be consistent with accepted, current clinical practice
- Provides more detailed information to providers, payers, and policy makers

ICD-10-CM vs ICD-9-CM

- ICD-10-CM codes
  - Alphanumeric; include all letters except U
- Maximum code length in ICD-10-CM = Seven characters
- ICD-9-CM’s V and E codes **INCORPORATED** into main ICD-10-CM classification
- ICD-10-CM - information relative to ambulatory & managed care encounters
ICD-10-CM vs ICD-9-CM

- Conditions new/not uniquely IDed in ICD-9-CM assigned ICD-10-CM code numbers
- ICD-10-CM has vacant 3-character categories for future expansion
- ICD-10-CM groups injuries first by site (for example, hand), and then type of injury
- ICD-10-CM provides expanded Excludes notes
- Conditions w/new tx protocols or recently discovered etiology listed in appropriate chapters

New/Expanded ICD-10-CM Features

- Combination codes used for symptoms, diagnoses, etiologies, and manifestations
- Laterality included in code expansions in neoplasm & injury chapters
- Patient’s trimester included in obstetrics codes
- Codes for insulin- and non-insulin-requiring types in diabetes section
- Codes for postoperative complications expanded
ICD-10-CM Improvements

• Conditions grouped more logically
• Subcategory titles more complete
• Fifth- and 6th-character sub-classifications
• Laterality of conditions at 5th- & 6th-character level
• Specificity increased
• Extensions provide more information

ICD-10-CM Improvements
• Combination codes group etiologies & manifestations
• Code titles reflect new technology & recent terminology
• Codes added to describe postoperative or post-procedural conditions
• Trimester specificity added
• Many new codes added
Structure of ICD-10-CM

- International ICD-10 classification has three volumes:
  - 1: Tabular List
  - 2: Guidelines
  - 3: Alphabetic Index

- ICD-10-CM has only two volumes:
  - 1: Tabular List (TL)
  - 2: Alphabetic Index (AI)

- Index to Injury and Diseases
- Neoplasm Table
- Table of Drugs & Chemicals
- Index to External Causes
External Cause section

- Main terms & modifiers indicate
  - Types of accidents or occurrences
  - Vehicles involved
  - Place of occurrence

Similarities
Basic ICD-10-CM Coding Steps

- ID all main terms in dx statement
- ID all modifiers (subterms) in dx statement
- Locate mainterm(s) in AI (disease, condition)
- Locate subterm(s) (site, etiology, clinical type)
- Follow any cross-references IF not under 1st code
- Verify tentative code in TL
- Follow any instructions
- Assign codes to highest level of specificity

Code Structure

- Three-character category w/o any subdivision = Code I20 Angina pectoris
- Subcategories = Codes with characters following point I20.0 Unstable angina

- Codes w/o correct # of characters = INVALID
  - Codes assigned MUST have highest # of characters available/highest level of specificity
Structure and Conventions

• Much of hierarchical structure similar
• Many conventions similar

Tabular List
• Chapters
• Subchapters (Blocks in ICD-10-CM)

Alphabetic Index
• Two parts
  • Index to Diseases and Injuries
    • Neoplasm Table
    • Table of Drugs & Chemicals
  • Index to External Causes

NO HTN Table in ICD-10-CM

Similar AI Conventions

• **Boldface** Maintainers
• Indented subterms/essential modifiers
• Non-essential modifiers in ( )
• See
• See Also
• See Condition

**Acanthosis** (acquired) (nigricans) L83
- benign Q82.8
- congenital Q82.8
- seborrheic L82.1
- - inflamed L82.0
- - tongue K14.3

**Addiction** (see also Dependence) F19.20
- alcohol, alcoholic (ethyl) (methyl) (wood) (without remission) F10.20
  - with remission F10.21
- drug —see Dependence, drug
- ethyl alcohol (without remission) F10.20
  - - with remission F10.21
Similar Conventions

• Abbreviations
  • NEC (Other Specified)
    • AI and TL
  • NOS (Unspecified)
    • TL only

Adventitious bursa —see Bursopathy, specified type NEC

Collapse R55
- during or
- - after labor and delivery 075.1
- - resulting from a procedure, not elsewhere classified

L23 Allergic contact dermatitis

Excludes:
  allergy NOS (T78.40)
  contact dermatitis NOS (L25.9)
  dermatitis NOS (L30.9)

Instructional Notes

• Includes
  • Examples
  • Location
  • Code first
  • Use add’l code
  • Code Also
    • No Sequencing

Instructional Notes Examples

Dermatitis and eczema (L20-L30)
Note: In this block, the terms dermatitis and eczema are used synonymously and interchangeably.

L24.2 Irritant contact dermatitis due to solvents
  Irritant contact dermatitis due to chloroform
  Irritant contact dermatitis due to cyclohexane
  Irritant contact dermatitis due to ester
  Irritant contact dermatitis due to glycol
  Irritant contact dermatitis due to hydrocarbon
  Irritant contact dermatitis due to ketone

L24.3 Irritant contact dermatitis due to cosmetics

L24.4 Irritant contact dermatitis due to drugs in contact with skin
  Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
Instructional Notes Examples

Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)

Includes: adverse effect of correct substance properly administered
- poisoning by overdose of substance
- poisoning by wrong substance given or taken in error
- underdosing by (inadvertently) (deliberately) taking less substance than prescribed or instructed

**Code first**, for adverse effects, the nature of the adverse effect, such as:
- adverse effect NOS (T68.7)
- aspirin gastritis (K29.7)
- blood disorders (D56-D76)
- contact dermatitis (L23-L25)
- dermatitis due to substances taken internally (L27.1)
- nephropathy (N14.0-N14.2)

**Note:** The drug giving rise to the adverse effect should be identified by use of codes from categories T36-T50 with fifth or sixth character 5.

**Use additional code(s) to specify:**
- manifestations of poisoning
- underdosing or failure in dosage during medical and surgical care (Y63.6, Y63.8-Y63.9)
- underdosing of medication regimen (Z91.12, Z91.13)

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Similar Conventions

- **Punctuation**
  - Brackets [ ]
    - TL
  - Parentheses ( )
    - AI and TL
  - Colon :
    - TL Notes

- **And = And/Or (TL)**

- **With = Associated with/due to**
  - Code Title, AI, TL
  - Subterm sequencing
**Similar Conventions Examples**

- **Brackets**
  
  B06, Rubella [German measles]
  J00, Acute nasopharyngitis [common cold]

  **Disease**, Alzheimer's G30.9 [F02.80]
  **Nephrosis**, in amyloidosis E85.4 [N08]

- **Parentheses**

  Anemia (essential) (general) (hemoglobin deficiency)
  Diabetes, diabetic (mellitus) (sugar)
  Hemophilia (classical) (familial) (hereditary)

  H44.611, Retained (old) magnetic foreign body in anterior chamber, right eye
  I10, Essential (primary) hypertension
  K51.011, Ulcerative (chronic) pancolitis with rectal bleeding

**AI Conventions Examples**

**Dementia** (degenerative (primary)) (old age) (persisting) F03.90
- with
  - - aggressive behavior F03.91
  - - behavioral disturbance F03.91
  - - combative behavior F03.91
  - - Lewy bodies G31.83 [F02.80]
  - - - with behavioral disturbance G31.83 [F02.81]
  - - Parkinsonism G31.83 [F02.80]
  - - - with behavioral disturbance G31.83 [F02.81]
  - - Parkinson's disease G20 [F02.80]
  - - - with behavioral disturbance G20 [F02.81]
Differences

ICD-10-CM Codes

• Sub-categories = 4 or 5 characters
• Codes are 3 – 7 characters
• 1st character is LETTER
  • O IS used; U is NOT used
• Code format

[Diagram showing code format with category, etiology, anatomic site, severity, and extension]
ICD 10 CM Code - Example

http://www.webpt.com/blog/post/understanding-icd-10-code-structure

Which of the following is a valid ICD-10-CM code?

- 428.9
- L03.313
- T37.0XX1A
- M12X.58
Tabular List

• TL = 21 chapters
  • List of BLOCKS at beginning of each chapter

• Axes of Classification
  • Body/organ system
  • Etiology/Disease process
  • E & V codes NOT supplemental

• Order of Chapters – some reordering
• Some chapters reordered
  • Injuries = 1st by specific site, then type of injury
  • Postop complications moved to procedure-specific body system (mostly)

AI Conventions

• Connecting words
  • Subterms
    • Indicate a relationship between main term and associated condition/etiology

• Associated with
• Due to
• In
• With mention of

• Complicated by
• Following
• Secondary to
Dashes in AI and TL

• AI – Dash at end of code = Incomplete code
  • MUST review TL
  • Ex: Fracture, traumatic
    - clavicle S42.00-

• TL - Dash preceded by decimal point (.-) = incomplete code
  • MUST review referenced code in TL
  • Ex: J43 Emphysema
    • Excludes1: emphysematous (obstructive) bronchitis (J44.-)

Exclusion Notes

• Two types
  • Category, subcategory, or code level

• Excludes1 – Pure, NOT CODED HERE!
  • NEVER used w/ code above note
  • Two conditions can’t occur together
    • Congenital and Acquired

• Excludes2 – Not coded here
  • Condition excluded NOT INCLUDED HERE
  • Patient may have both at same time
  • Can code both WHEN both present
Excludes Notes Examples

L02.2 Cutaneous abscess, furuncle and carbuncle of trunk

**Excludes1:** non-newborn omphalitis (L08.82)

- omphalitis of newborn (P38.-)

**Excludes2:** abscess of breast (N61)

- abscess of buttocks (L02.3)
- abscess of female external genital organs (N76.4)

TL Conventions Examples

G20 Parkinson's disease
- Hemiparkinsonism
- Idiopathic Parkinsonism or Parkinson's disease
- Paralysis agitans
- Parkinsonism or Parkinson's disease NOS
- Primary Parkinsonism or Parkinson's disease

**Excludes1:** dementia with Parkinsonism (G31.83)

F02 Dementia in other diseases classified elsewhere

**Code first** the underlying physiological condition, such as:
- Alzheimer's (G30.-)
- cerebral lipodosis (E75.4)
- niacin deficiency [pellagra] (E52)
- Parkinson's disease (G20)
- Pick's disease (G31.01)
External Causes of Morbidity

- ICD-10-CM Chapter 20 (V01-Y99)
- **Secondary** codes in any HC setting
- Data for
  - Injury research
  - Evaluation of injury prevention strategies
- Codes capture
  - How (cause)
  - Intent
  - Where (place)
  - What (activity)

External Causes Codes

- Most applicable to injuries
- Can be used for
  - Infections/Diseases due to external source
  - Other conditions
    - Heart Attack occurring during strenuous activity
    - Clearing Limbs after Hurricane Irene
- **Separate** Index
External Cause Code Guidelines

• Assign external cause code w/7th character for EACH encounter for tx
• Use FULL range of external cause codes
  • Cause
  • Intent
  • Place of occurrence – only ONCE - initial
  • Activity of Patient – only ONCE – initial
    • NOT used with poisonings, adverse effects, misadventures, or sequelae
• Combination codes = injury sequence

Morphology Codes

• No longer listed in AI with descriptors and standard ICD-10-CM codes
• No longer separate appendix in ICD-10-CM
NEC and NOS Separated

- Other Specified and Unspecified each have their own code

- Example:
  
  L60.8  Other nail disorders
  L60.9  Nail disorder, unspecified

ICD-10-CM Table of Neoplasms

- Part of AI
- Alphabetic order according to anatomic site
- 6 possible codes available for each site, and assignment based on neoplasm behavior
  - Malignant (primary/secondary), benign, in situ, of uncertain behavior, or of unspecified behavior
Placeholder Character (X)

- **Two** uses
  - Future expansion **WITHOUT** disturbing overall code structure (5th character for some 6-character codes)
  - Code with <6 characters requiring a 7th character extension
    - Obstetrics, Injuries, and External causes of injuries

- **Placeholder Examples**
  - T37.0X1A, Poisoning by sulfonamides, accidental (unintentional), initial encounter
  - T56.0X2S, Toxic effect of lead and its compounds, intentional self-harm, sequela
  - W42.0XXA, Exposure to supersonic waves, initial encounter
Pregnancy Trimester Coding

- Inclusion of trimesters in obstetrics codes
  - Episode of Care 5th Digits **Eliminated**
- Examples:
  - O10.012, Pre-existing essential hypertension complicating pregnancy, second trimester
  - O99.013, Anemia complicating pregnancy, third trimester
Pregnancy Trimester Example

- O10.0 Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium
  Any condition in I10 specified as a reason for obstetric care during pregnancy, childbirth or the puerperium
- O10.01 Pre-existing essential hypertension complicating pregnancy,
- O10.011 Pre-existing essential hypertension complicating pregnancy, first trimester
- O10.012 Pre-existing essential hypertension complicating pregnancy, second trimester
- O10.013 Pre-existing essential hypertension complicating pregnancy, third trimester
- O10.019 Pre-existing essential hypertension complicating pregnancy, unspecified trimester
- O10.02 Pre-existing essential hypertension complicating childbirth
- O10.03 Pre-existing essential hypertension complicating the puerperium

Seventh Character

- SOME ICD-10-CM categories require 7th character to further specify condition
  - May be number OR letter
  - MUST always be 7th character
- Examples:
  - O65.0XX1, Obstructed labor due to deformed pelvis, fetus 1
  - S02.110B, Type I occipital condyle fracture, initial encounter for open fracture
  - T17.220D, Food in pharynx causing asphyxiation, subsequent encounter
Specificity

- Laterality
- Other expanded detail
- Combined in single code
  - Etiology and manifestations
  - Poisoning and external cause
  - Diagnosis and symptoms
- Code titles and language complement accepted clinical practice

Specificity Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L89.13</td>
<td>Pressure ulcer of right lower back</td>
</tr>
<tr>
<td>L89.130</td>
<td>Pressure ulcer of right lower back, unstageable</td>
</tr>
<tr>
<td>L89.131</td>
<td>Pressure ulcer of right lower back, stage 1</td>
</tr>
<tr>
<td></td>
<td>Healing pressure ulcer of right lower back, stage 1</td>
</tr>
<tr>
<td></td>
<td>Pressure pre-ulcer skin changes limited to persistent focal edema, right lower back</td>
</tr>
<tr>
<td>L89.132</td>
<td>Pressure ulcer of right lower back, stage 2</td>
</tr>
<tr>
<td></td>
<td>Healing pressure ulcer of right lower back, stage 2</td>
</tr>
<tr>
<td></td>
<td>Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, right lower back</td>
</tr>
<tr>
<td>L89.133</td>
<td>Pressure ulcer of right lower back, stage 3</td>
</tr>
<tr>
<td></td>
<td>Healing pressure ulcer of right lower back, stage 3</td>
</tr>
<tr>
<td></td>
<td>Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue, right lower back</td>
</tr>
<tr>
<td>L89.134</td>
<td>Pressure ulcer of right lower back, stage 4</td>
</tr>
<tr>
<td></td>
<td>Healing pressure ulcer of right lower back, stage 4</td>
</tr>
<tr>
<td></td>
<td>Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone, right lower back</td>
</tr>
<tr>
<td>L89.139</td>
<td>Pressure ulcer of right lower back, unspecified stage</td>
</tr>
<tr>
<td></td>
<td>Healing pressure ulcer of right lower back NOS</td>
</tr>
<tr>
<td></td>
<td>Healing pressure ulcer of right lower back, unspecified stage</td>
</tr>
</tbody>
</table>
Specificity Examples

S20.35  Superficial foreign body of front wall of thorax
         Splinter in front wall of thorax
         S20.351  Superficial foreign body of right front wall of thorax
         S20.352  Superficial foreign body of left front wall of thorax
         S20.359  Superficial foreign body of unspecified front wall of thorax

S20.36  Insect bite (nonvenomous) of front wall of thorax
         S20.361  Insect bite (nonvenomous) of right front wall of thorax
         S20.362  Insect bite (nonvenomous) of left front wall of thorax
         S20.369  Insect bite (nonvenomous) of unspecified front wall of thorax

S20.37  Other superficial bite of front wall of thorax
         Excludes1: open bite of front wall of thorax (S21.14)
         S20.371  Other superficial bite of right front wall of thorax
         S20.372  Other superficial bite of left front wall of thorax
         S20.379  Other superficial bite of unspecified front wall of thorax

Specificity Examples

E11.4  Type 2 diabetes mellitus with neurological complications
         E11.40  Type 2 diabetes mellitus with diabetic neuropathy, unspecified
         E11.41  Type 2 diabetes mellitus with diabetic mononeuropathy
         E11.42  Type 2 diabetes mellitus with diabetic polyneuropathy
                   Type 2 diabetes mellitus with diabetic neuralgia
         E11.43  Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
                   Type 2 diabetes mellitus with diabetic gastroparesis
         E11.44  Type 2 diabetes mellitus with diabetic amyotrophy
         E11.49  Type 2 diabetes mellitus with other diabetic neurological complication
Timeframe Changes for Some Codes

• Examples:
  • AMI - Time period changed from 8 wks to 4 wks
  • Abortion vs fetal death – Time period changed from 22 weeks to 20 weeks

Timeframe Examples

I21  ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction

Includes: cardiac infarction
  coronary (artery) embolism
  coronary (artery) occlusion
  coronary (artery) rupture
  coronary (artery) thrombosis
  infarction of heart, myocardium, or ventricle

  myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset.
Abortion/Fetal Death - TL

O02.1 Missed abortion
Early fetal death, before completion of 20 weeks of gestation, with retention of dead fetus
Excludes1: failed induced abortion (O07.-)
- fetal death (intrauterine) (late) (O36.4)
- missed abortion with blighted ovum (O02.0)
- missed abortion with hydatidiform mole (O01.-)
- missed abortion with nonhydatidiform (O02.0)
- missed abortion with other abnormal products of conception (O02.8-)
- missed delivery (O36.4)
- stillbirth (P95)

O36.4 Maternal care for intrauterine death
Maternal care for intrauterine fetal death NOS
Maternal care for intrauterine fetal death after completion of 20 weeks of gestation
Maternal care for late fetal death
Maternal care for missed delivery
Excludes1: missed abortion (O02.1)
- stillbirth (P95)

Other ICD-10-CM TL Conventions

- **Deactivated codes** are codes that are used in ICD-10, but **not** in ICD-10-CM

- Braces and section mark symbols are **NOT** used in ICD-10-CM
Break Time

• Fluid Exchanges

ICD-10-CM Coding Guidelines

• Section I
  • Structure and conventions of classification
  • General guidelines that apply to entire classification
  • Chapter-specific guidelines correspond to chapters as arranged in classification

• Section II
  • Selection of principal diagnosis for non-outpatient settings

• Section III
  • Reporting additional diagnoses in non-outpatient settings

• Section IV
  • Outpatient coding and reporting
ICD-10-CM Coding Guidelines
• Similar to ICD-9-CM, EXCEPT
• Laterality (New)
• Documentation of Complications of Care

General
ICD-10-CM Coding Guidelines
Chapter 1, pp. 22-27
Laterality Guideline

• For bilateral sites, final code character indicates laterality
• Unspecified site code also provided IF side NOT identified in medical record
• When no bilateral code provided and condition bilateral, assign separate codes for Left and Right side

Documentation for BMI

• Guideline I.B.14
• Can use other clinicians’ documentation for specific code
• BUT patient’s Provider MUST document associated Dx
• IF conflicting info, must query attending physician
• BMI codes = add’l Dx codes ONLY
Documentation of Complications of Care  I.B.16

• Code assignment based on provider’s documentation of relationship bet. Condition/care or procedure
• Guideline extends to any complications of care, regardless of chapter where code located
• Important to note NOT all conditions occurring during/following medical care/surgery classified as complications

Documentation of Complications of Care  I.B.16

• Must be cause-&-effect relationship bet. care provided & condition, and indication in documentation that it is complication
• Query provider for clarification, if complication not clearly documented
Documentation for Pressure Ulcer Stages

• Guideline I.B.14
• Can use other clinicians’ documentation for specific code
• BUT patient’s Provider MUST document associated Dx
• IF conflicting info, must query attending physician

General Coding Guidelines

• Acute and Chronic Conditions
  • When Pt has both AND AI lists at SAME level, code BOTH

- Bronchiolitis (acute) (infective) (subacute) J21.9
  - with
    - bronchospasm or obstruction J21.9
    - influenza, flu or grippe — see Influenza, with respiratory symptoms J09.9
    - chemical (chronic) J68.4
    - acute J68.0
    - chronic (fibrosing) (obliterative) J44.9

- Bronchitis (diffuse) (fibronous) (hypostatic) (infective), J40
  - with
    - influenza, flu or grippe — see Influenza, with respiratory symptoms J09.9
    - obstruction (airway) (lung) J44.9
    - tracheitis (15 years of age and above) J40
    - acute or subacute J20.9
    - chronic J42
    - under 15 years of age J20.9
General Coding Guidelines

• Combination Codes
  • One code =
    • Two diagnoses
    • Dx & assoc. 2ndary process/manifestation
    • Dx with assoc. complication
  • Ex: Pt w/acute bronchitis with Bronchiectasis and tobacco use

General Coding Guidelines

• Impending/Threatened Conditions
  • Described at TIME of **Discharge**
  • IF occurred, code as confirmed
  • IF did not occur, check AI for “impending/threatened” subterm and Impending/Threatened Main Terms
  • IF not listed, Code existing UNDERLYING conditions
General Coding Guidelines

• Integral Conditions
  • S&S integral to Dx NOT add’l codes
  • **Coder’s medical knowledge essential here**
• Non-Integral Conditions
  • Same Dx code reported more than once
    • Report each Dx code only once for an encounter

General Coding Guidelines

• Level of Code Detail
  • MUST code to level of detail provided in TL
• Locating a code
  • MUST use BOTH AI and TL
General Coding Guidelines

• Sequela/(Late Effects in ICD-9-CM)
  • Sequela = Condition produced by another illness/injury **AND** remains after acute phase
  • NO time period for when sequela must present
    • Same time as original disease (Dysphagia w/CVA)
    • After acute phase (Scar, Contracture)
  • TWO codes required (usually)
    • 1st code = Sequela (existing condition)
    • 2nd code = original causal condition (but NOT acute code) See Example on page 25

General Coding Guidelines

• S&S Signs and Symptoms
  • Appropriate when only info known
  • Info at beg. of ICD-10-CM Chapter 18
  • Not routinely part of Dx = add’l code

• Syndromes
  • I.B.15
  • Follow AI when coding named syndromes
  • When syndrome not listed in AI, code for each documented manifestations/conditions id as syndrome
Sequencing Guidelines
Inpatient PrDx
Inpatient Add’l Dx
Outpatient Services

Chapter 3, pp. 56-67

Inpatient Settings

• UHDDS –
  • Acute care, short-term, long-term care, psychiatric hospitals
  • All NON-outpatient settings
    • Above
    • HHAs
    • Rehab Facilities
    • Nursing Homes
Inpatient Guidelines

- Circumstances of admission govern selection
  - “... condition determined AFTER STUDY to be chiefly responsible for the admission to hospital” (UHDDS)
- ICD-10-CM AI and TL have precedence
  - Code first, Use Add’l, etc.

Inpt Sequencing Guidelines

- II. A. Once a diagnosis established that reflects S&S, code only definitive dx

- II. B. Two or more INTERRELATED conditions, each meeting definition of PrDx
  - Either can be PrDx, UNLESS admission circumstances, Tx provided, TL, AI indicate otherwise
Inpt Sequencing Guidelines

• II. C. Two+ diagnoses equally qualify as PrDx, any one can be sequenced first

• II.D. Two+ Comparative/Contrasting Dx
  • Either/or, versus, etc.
  • Still contrasting at time of D/C
  • Coded as confirmed
  • Sequenced following previous guidelines

Inpt Sequencing Guidelines

• II. E. Symptom followed by contrasting/comparative Dx
  • Symptom sequenced first, followed by all contrasting dx

• II. F. Original tx plan NOT carried out
  • PrDx still condition that AFTER study occasioned admission
Inpt Sequencing Guidelines

• II. G. Complication of surgery/medical care
  • Admission for care of Complication = Complication is PrDx
  • Ex: Pt admitted to treat atelectasis due to recent cardiovascular surgery
  • AI – Atelectasis J98.11
  • AI - Complications, surgical care, respiratory
    • See Complications, respiratory system
  • AI – Complications, respiratory system
    • Postop – J95.9
    • Specified NEC J95.89

Inpt Sequencing Example (p. 59)

J95.89  Other postprocedural complications and disorders of respiratory system, not elsewhere classified

Use additional code to identify disorder, such as:
  aspiration pneumonia (J69-)
  bacterial or viral pneumonia (J12-J18)

Excludes: acute pulmonary insufficiency following thoracic surgery (J95.1)
  postprocedural subglottic stenosis (J95.5)

J98.1  Pulmonary collapse
  Excludes: therapeutic collapse of lung status (Z98.3)

J98.11  Atelectasis
  Excludes: newborn atelectasis
tuberculous atelectasis (current disease) (A15)

J98.19  Other pulmonary collapse

J95.89  J98.11
Inpatient Sequencing Guidelines

• II. H. Uncertain Dx
  • Probable, Suspected, Likely, Questionable, Possible, Rule out, Etc.
  • Rule Out Pneumonia     RO Pneumonia
  • Pneumonia Ruled Out   Pneumonia RO
  • Code condition as if was established
  • NB: Inpt admissions ONLY !

• Admission from Observation
• Admission from Outpatient Surgery

Watch Out!

Inpatient Sequencing Guidelines

• II.I. Admission from Observation Unit
  • Dx that caused observation unit admission
  • SAME Dx worsens/does not improve
  • Admitted to same Hospital for Same Dx
  • Hospital Dx is medical condition that led to admission

• II.J. Admission from Outpatient Surgery
  • To Same Hospital’s Inpatient status
  • Complication of surgery = PDx
  • Unrelated condition = PDx
### Inpatient Add’l Dx Guidelines

- **Other Dx =** Conditions that require clinical evaluation = Code
  - Physician considered condition while examining patient
  - Testing
  - Closely observing
  - Diagnostic Proc, Tx

- **Other Dx Reportable**
  - Clinical Evaluation
  - Therapeutic Tx
  - Diagnostic Proc
  - Extended LOS
  - Increased Nursing Care/Monitoring

- **No sequencing guidelines**
  - More significant listed ahead of others
  - Received most attention

### Inpatient Add’l Dx Guidelines

- **III. A.** Previous conditions are coded ONLY when affect current admission
  - Hx codes may be used when impact care or influence tx

- **III. B. Abnormal Findings**
  - NOT coded unless provider indicates clinical significance
  - Query when attending ordered other test/provided tx
Inpatient Add’l Dx Guidelines

• III. C. Uncertain Dx
  • Probable, Suspected, Likely, Questionable, Possible, Rule out, Etc.
  • Code condition as if were established

• NB: Inpt admissions ONLY
Outpatient Guidelines

- **Settings**
  - Hospital Outpatient
  - Physician’s Office
  - Other Ambulatory Care Center

- **Coding Goal** = Code what is certain at encounter, focus of care at that time

- **Encounter** = Visit

Outpatient Guidelines

- **A. First-Listed Dx**
  - ICD-10-CM Conventions & Guidelines take precedence
  - 2+ visits may be needed to determine Dx

- **A.1. Outpatient Surgery**
  - Reason for Surgery = First-listed Dx, even if NOT performed

- **A.2. Observation Stay**
  - Medical condition being observed = 1st L Dx
  - For complication Following Outpt Surgery, Reason for Surgery = 1st L Dx, Complication = Add’l Code
Outpatient Guidelines

• B. All ICD-10-CM codes appropriate for coding outpatient visits
• C. Accurate coding/reporting requires documentation describing pt’s conditions – dx, S&S, problems, reasons for visit
• D. S&S codes – coded when Dx not established (confirmed) by provider

Outpatient Guidelines

• E. Visit for reason other than disease/injury
  • Z00-Z99 Factors Influencing Health Status and Contact with Health Services
    • Vaccinations, Well-Baby Exams, Sports Physicals, Living Organ Donors, etc.
Outpatient Guidelines

• F. Level of Coding Detail
  • MUST code to available level of detail
  • 3 – 7 characters; some codes only 3;
    some require up to 7

• G. First-Listed code = diagnosis, condition,
  problem, symptom, other reason for visit to be
  chiefly responsible for services provided

Outpatient Guidelines

• H. Uncertain Dx
  • *DO NOT code Probable, Suspected,
    Questionable, Rule Out, Working Dx, etc.
  • Code to highest degree of certainty
    • S&S, Abnormal Test results, other

* Differs from INPT Guidelines
Outpatient Guidelines

I. Chronic Diseases

• Ongoing tx – code as many times as patient receives tx

J. Coexisting Conditions

• Code conditions requiring/affecting patient care, treatment, or management
• DO NOT code previous conditions no longer existing
• Hx codes may be used when have impact on current care/influence tx

K. Patients rec. Diagnostic services ONLY

• 1st-listed Dx – issue most related to services provided
• May code other add’l dx
• Routine Lab/Radiology testing w/NO S&S, Dx
  • Z01.89 = 1st-listed Dx
  • IF routine testing also done for S&S or Dx, code both Z01.89 and Dx code
• *When Test result INTERPRETATION by PHYSICIAN available on MR
  • Code confirmed/definitive Dx, and DO NOT code any related S&S

* Differs from INPT Guidelines
Outpatient Guidelines

L. Patients rec. Therapeutic Services ONLY
   • 1st-Listed Dx = issue chiefly responsible for services provided
   • May code other add’l dx

   • EXCEPTION: Primary reason for visit is Chemo/Radiation Tx
     • Z code for tx = 1st-listed Dx;
     • Then code service-related dx

Outpatient Guidelines

M. Patients rec. Preoperative Evals ONLY
   • 1st-Listed code = Z01.81-
   • Also code condition = reason for surgery
   • Also code any pre-op test findings

N. Ambulatory Surgery
   • 1st-Listed Dx = reason performed
   • Use Post-Op Dx if differs from Pre-Op Dx
Outpatient Guidelines

O. Routine Outpatient Prenatal Visits

• I. C. 15. b. 1.

Routine outpatient prenatal visits when no complications present, code from category Z34, Encounter for supervision of normal pregnancy, should be used as first-listed diagnosis.

These codes should **not** be used in conjunction with chapter 15 codes.

---

Outpatient Guidelines

P. Visits for general med exams w/abnormal findings

• 1st-Listed Dx = Z00.0-
  • Category provides codes for w/wo abnormal findings
  • Add’l code for abnormal finding
Outpatient Guidelines

Q. Visits for Routine Health Screenings

• I.C.21.
• Screening code may be 1st-listed code if reason for visit specifically screening exam. Also used as add’l code if screening done during visit for other health problems. Screening code NOT necessary if screening inherent to routine exam, such as pap smear done during routine pelvic exam
• IF condition found during screening, then code for condition may be Add’l Dx
• Z code indicates screening exam planned. Procedure code required to confirm screening performed

Respiratory Example 1

The following documentation is the discharge progress note from an observation case.

Nephrology Attending
Patient is doing somewhat better. Slight cough. Afebrile. Pulmonology has been here to consult. Ordered PEEP valve training for airway clearance.

Temp 37, P 115, R22, BP 100/68
No acute distress. Cushingoid facies. RRR with no murmur. Lungs clear bilaterally. Abdomen soft, non-tender, not distended. No edema and no rash.

Blood culture was negative x 24 hours. CXR – mild peribronchial thickening. Urine not sent for culture.

Assessment/Plan: Viral URI and neutropenia in a six year old male with Wegener's granulomatosis.

Urine for culture. Respiratory therapy training today. Discharge home after training and ceftriaxone dose this evening. CBC with diff on Monday in my office. Assign the correct diagnostic code(s).
Example 1 ANSWER

J06.9  Infection, infected, infective (opportunistic) respiratory (tract). upper (acute), viral NOS
D70.9  Neutropenia, neutropenic (chronic) (genetic) (idiopathic) (immune) (infantile) (malignant) (pernicious) (spleenic)
M31.30 Granulomatosis, Wegener's

Rationale: The reason for the encounter is the viral URI and neutropenia. The Wegener's granulomatosis is a secondary diagnosis. Viral URI is a combination code in ICD-10-CM.

Digestive Example 1

• Acute gastric ulcer with hemorrhage

Ulcer, ulcerated, ulcerating, ulceration, ulcerative
- bleeding K27.4
- gastric — see Ulcer, stomach
- stomach (eroded) (peptic) (round) K25.9
  - with
  - - - hemorrhage K25.4
  - - - and perforation K25.6
  - - - perforation K25.5
  - - acute K25.3
  - - with
  - - - hemorrhage K25.0
  - - - - and perforation K25.2
  - - - perforation K25.1
Digestive Example 2

- Choledocholithiasis with acute cholangitis and obstruction

**Choledocholithiasis** (common duct) (hepatic duct) — see Calculus, bile duct

**Calculation, calculi, calculous**

- bile duct (common) (hepatic) K80.50
- - with
- -- calculus of gallbladder — see Calculus, gallbladder and bile duct
- -- cholangitis K80.30
- -- - with
- --- - cholecystitis — see Calculus, bile duct, with cholecystitis
- --- - obstruction K80.31
- --- - acute K80.32
- --- - with
- ------ chronic cholangitis K80.36
- ------ - with obstruction K80.37
- ------ obstruction K80.33

Watch Out! For Indentions

Injury Example Case 1

- While walking to her car from her house, pt fell in driveway, landing on her L knee, striking her L shoulder. Pt's R foot is swollen, bruised, and sore to touch.
- X-ray of R foot reveals fx of proximal 5th metatarsal.
- Pt placed in walking boot, to return in 2 wks to evaluate healing.
Injury Example Case 1 Codes

- ICD-9-CM Codes:
  - 825.25 Fx metatarsal bone(s) closed
  - E888.8 Other accidental fall
  - E001.0 Activities involving walking, marching and hiking
  - E849.0 Home accidents

- ICD-10-CM Codes:
  - S92.354A Nondisplaced fx of 5th metatarsal bone, R foot, initial encounter, closed fx
  - W18.30XA Fall on same level, unspecified, initial encounter
  - Y93.01 Activity, walking, marching and hiking
  - Y92.014 Private driveway to single-family (private) house

Injury Example Case 2

- A 20 year old female cut off her right index finger tip with a slicer at work.
  - Dx: Amputation; Avulsion?

- Body part = Finger, Index
- Laterality = Right
- External Cause = Slicer
- Place of Occurrence = Work
- Activity = Employed
Injury Example Case 2 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S68.610A</td>
<td>Complete traumatic transphalangeal amputation of right index finger, initial encounter</td>
</tr>
<tr>
<td>W31.82XA</td>
<td>Contact with other commercial machinery, initial encounter</td>
</tr>
<tr>
<td>Y99.0</td>
<td>Civilian activity done for income or pay</td>
</tr>
</tbody>
</table>

Injury Example Case 3

- Degloving injury; Ring caught on Handrail screw while leaving subway
  - Body part
  - Bone
  - Joint
  - Cause
  - Activity & Status
Documentation needed

• Complete vs partial amputation of finger
• Specific finger must be identified
• Encounter (initial, subsequent, sequelae)

Injury Example Case 3
ANSWER

• S68.614A Complete traumatic amputation of right ring finger, initial encounter

• Specific code for each finger (6th character)
• 5th character defines complete or partial amputation
• Codes are not differentiated by presence or absence of complication
• 7th character identifies specific encounter
Injury Example Case 3
External Cause codes

- W23.1XXA Caught, crushed, jammed, or pinched between stationary objects, initial encounter
- Y92.522 Railway station as the place of occurrence of the eternal cause
- Y99.8 Other external cause status

Homework

- Chapter 1, Exercises 1.1 - 1.6 ODD
- Chapter 1, Review Exercise
  - Any 10 that most relate to your coding

- Chapter 3, Review Exercise
  - 7, 8, 11, 15, 16, 17, 18
Resources

- AAPC. ICD-10 hub.
  http://www.icd10hub.com/index.php
- AHIMA. ICD-10-CM/PCS
  - http://www.ahima.org/topics/icd10
- CMS Sponsored ICD-10 Teleconferences
- CMS. ICD-10 Resources

Resources

Funny ICD-10 Codes - PART 1. Target Coding
  https://www.youtube.com/watch?v=_U7GWbYUM6c
  - http://dch.georgia.gov/icd-10-videos-preparing-implementation
Resources

• ICD-10 Coding Basics 01/14/14. MLN Connects. CMS.
  https://www.youtube.com/watch?v=kCV6aFlA-Sc

• ICD-10 Training Course. CodeBusters.
  • http://www.codebusters.com/icd-10-training/

• ICD-10-CM Official Guidelines for Coding and Reporting (current ed.)
  • http://www.cdc.gov/nchs/icd/icd10cm.htm

Resources


• Understanding the ICD-10 Code Structure
  • http://www.webpt.com/blog/post/understanding-icd-10-code-structure
Questions ???

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Thank You!